Delayed Reaction to Trauma in an Aging Woman

by DARNELL LADSON, DO; and DAVID BIENENFELD, MD

AUTHOR AFFILIATIONS: All from the Department of Psychiatry, Wright State University Boonshoft School of Medicine, Dayton, Ohio

ABSTRACT

Events of later life may awaken long-suppressed memories and feelings and yield emotional or behavioral problems that are evidence of an early traumatic experience. It is believed that posttraumatic stress disorder (PTSD)-like symptoms are more prevalent in the younger general population, but the lack of data supporting PTSD in the elderly may be due to the complicated presentation. The elderly often present to psychotherapy with comorbid diagnoses and may underreport their symptoms, or the symptoms may be masked by other diagnoses. PTSD is associated with increased rates of major depressive disorder, substance-related disorders, panic disorder, agoraphobia, obsessive-compulsive disorder, generalized anxiety disorder, social phobia, specific phobia, and bipolar disorder. Most of the literature on PTSD in the elderly stems from research on Holocaust or World War II survivors. In this paper, we will explore this particular dimension of late-life onset mental disorder with attention to the relevance of old trauma in performing psychodynamic psychotherapy.

INTRODUCTION

The elderly population is expected to grow to more than 70.3 million in 2030.[1] With this in mind, it is imperative that we examine the ways in which we view mental disorders in late life. We know from census reports

EDITOR'S NOTE: All cases presented in the series "Psychotherapy Rounds" are composites constructed to illustrate teaching and learning points, and are not meant to represent actual persons in treatment.

ADDRESS CORRESPONDENCE TO: Darnell Ladson, DO, Department of Psychiatry, Wright State University Boonshoft School of Medicine, Box 927, Dayton OH 45401-0927; Phone: (937) 223-8840; E-mail: darnell.ladson@wright.edu

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that older adults are twice as likely as the general population to report mental disabilities.[2] Coping with physical illness, disability, or a diminished capacity for physical activity; adapting to retirement or reduced productivity at work; and dealing with grief after the loss of friends or a spouse are all frequent and challenging issues in late life.[3] The elderly often present with comorbid diagnoses and may underreport their symptoms or the symptoms may be masked by other diagnoses. In addition, many older adults may not seek care due to apprehension. This poses certain challenges when providing psychotherapy to older adults and requires that the therapist or psychiatrist (as in the case described here) be empathic and attentive to the special needs of this population.

A particular dimension of late-life-onset mental disorder came to our attention in the course of conducting psychotherapy, namely the delayed emergence of response to earlier trauma. In aging individuals, the classical symptoms of posttraumatic stress disorder (PTSD) may not be manifest, yet considerable distress may occur in the face of re-awakened memories of traumatic experiences. In this article, we will explore the complexities of diagnosing and managing reemerging PTSD in late life.

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CASE PRESENTATION

Ms. A (a composite case) was a 66-year-old married woman who came for psychotherapy for worsening depression and anxiety. The patient had a history of depression, which started when she was a young adult. Following her initial diagnosis, she continued to seek treatment for her depression with varying degrees of success. The patient was curt in discussing the details of her previous psychotherapy experiences, which did not raise any concerns initially but would later be a crucial element in the therapy.

Ms. A reported that she was having decreased energy and feeling less productive at home and work. She was withdrawing from her usual activities and not finding pleasure in her daily activities. She experienced decreased motivation for attending the spa or church activities. The patient reported that many of her concerns developed as a result of financial difficulties and workplace stress. She had recently exhibited cervical dysplasia, which required frequent gynecologic attention. Her doctors had told her the condition was benign, and she denied having any concerns about her cervical condition, though she did voice numerous other vague somatic complaints. Later, we would come to appreciate the significant impact her interaction with her doctors had on her current symptoms.

FIRST COURSE OF PSYCHOTHERAPY

The patient and psychiatrist agreed that brief therapy would be appropriate at the time based on her initial complaint. The psychiatrist felt that the identified focus for therapy should be Ms. A's financial stress and the ambivalence she felt about having to work in her later years, since her anxiety appeared greatest around these discussions. According to Baldwin, brief focused dynamic psychotherapy is appropriate for mild to moderate depression in late life when there is a focal issue that can be identified as underlying the symptoms.[4] The patient was scheduled for 12 sessions with an established end date. Each weekly session would last 50 minutes. The patient agreed that the focus would be her anxiety at work and her feelings of stagnation.

During the initial sessions, all efforts were made toward establishing an alliance and being responsive to the patient. Ms. A would often begin the sessions by describing in significant detail her somatic complaints. Over the next several weeks, the patient gained greater insight regarding her feelings of stagnation and anxiety. During this time, the patient sought out a new position within her company and began to involve herself in social activities. She reported that her mood had improved and she was less worried about her finances. By her self reports, she seemed to be doing better. As they approached the last few sessions of her therapy, the patient and the psychiatrist agreed that termination would be appropriate. The psychiatrist noted some degree of reservation he felt about termination at that time due to the patient's history of relapse following previous psychotherapy courses with other providers. Ms. A never made clear what issues, if any, she had had with the prior psychotherapy courses.

SECOND COURSE OF PSYCHOTHERAPY

Several months went by before the psychiatrist received a phone call from Ms A requesting to be seen once again. Ms. A informed the psychiatrist that she had not been doing well. She was having episodes of severe anxiety that were paralyzing. She was having further difficulty performing in her new job.

Once Ms. A returned to therapy, she expressed feelings of having the world closing in on her. She wanted reassurance and did not feel like she was able to talk to her husband about her concerns. She did not know who

she could trust. She spoke about being "found out" by her coworkers. The psychiatrist subtly asked the patient about what Ms. A thought her coworkers would find out and if she felt comfortable talking about it during the session. This discussion carried over for a few sessions before Ms. A revealed that she had a history of sexual trauma. Many years ago, when Ms. A was in her 20s, she was manipulated into performing sexual acts with her boss at the company where she was employed. He gave strong indications that her success on the job would hinge on her complying with his requests for intercourse in his office. After several months of trying to end this relationship, Ms. A left the company and got a job elsewhere.

Through further discussion, it became evident that the sexual trauma Ms. A had experienced decades earlier was being re-ignited by her medical circumstances. Her gynecologist of many years had retired, and Ms. A was now receiving care from a large practice with multiple physicians. Her frequent pelvic examinations were performed by a rotating group of several physicians, all of whom felt unfamiliar and uncomfortable to her. Ms. A felt violated at each checkup, and remembered the coerced sex with her boss years ago. The patient acknowledged that she had returned to therapy because she wanted to address the unresolved issues of guilt, shame, and disappointment she felt.

The psychiatrist's initial reaction was one of disappointment. He felt as though he had somehow failed his patient. The termination after the brief therapy had been so gratifying, and he questioned whether he was overly enthusiastic in wanting to believe his patient was better and, therefore, missed important clues that would have unveiled the trauma history that she ultimately revealed.

At this time, it was clear that the patient would require more than a brief intervention to address what appeared to be PTSD symptoms. The patient reported feeling as though her brain could no longer suppress the thoughts she had inside. This made it difficult for her to focus at work. She especially sought to minimize interaction with her male supervisor. She was unable to follow through with tasks at home, such as getting her meals prepared or laundry done. She constantly felt tired, which seemed more prominent in the evening and on weekends. She began to have difficulty remaining asleep. She became increasingly irritable with her husband and colleagues. Ms. A began to experience even more anxiety before and after each appointment with her gynecologist office. Furthermore, she was unable to engage in a sexual relationship with her husband, because she reported that sex reminded her of her past, and she did not feel prepared to handle it.

The psychiatrist focused on empathic listening, exploratory inquiry, and interpretation and clarification of unconscious determinants, which Morgan believes is an essential part of psychodynamic therapy.[5] It was even more important with this patient; due to the destructive experience with her previous boss, there was the likelihood Ms. A would see the psychiatrist as another man in a position of authority over her and would be distrustful of him.

DISCUSSION: SPECIAL POPULATION

PTSD consists of core symptoms of hypervigilance, intrusive thoughts, and avoidance after experiencing a traumatic event.[6] The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse or domestic battering): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

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Although the patient did not experience trauma in the sense of an event outside the realm of normal human experience, she did display many of the symptoms that would be consistent with the diagnosis of PTSD and subjectively experienced the sexual imposition of the prior therapist as traumatic. She experienced insomnia; avoidant behavior; poor concentration; hostility; social withdrawal; feelings of ineffectiveness and shame; and impairment of her relationships with increased somatic complaints. These symptoms had been present for greater than one month and caused significant impairment in functioning. The patient managed to keep these symptoms under control until the need for pelvic examinations rekindled the suppressed memories.

It is not uncommon for elderly patients with early traumatic experiences to make it through adult life with minimal sequelae until later years. A significant proportion of the population who are traumatized during their younger years manage to cope and function by maintaining a rigid problem-solving-focused stance in their coping style as well as maintain an internal locus of control.[7]

DIFFICULTY IN DIAGNOSING

Most of the literature on PTSD in the elderly stems from research on Holocaust or World War II survivors.[7] It is commonly believed that PTSD symptoms are more prevalent in the younger general population. The lack of data regarding PTSD in the elderly may be due to the complicated presentation. The elderly often present with comorbid diagnoses and may underreport their symptoms, or the symptoms may be masked by other diagnoses. PTSD is associated with increased rates of major depressive disorder, substance-related disorders, panic disorder, agoraphobia, obsessive compulsive disorder, generalized anxiety disorder, social phobia, specific phobia, and bipolar disorder. Depression is by far the most common comorbid condition. These disorders can precede, follow, or emerge concurrently with the onset of PTSD.[8] This makes diagnosis and treatment very difficult.

It is just as challenging distinguishing somatic complaints from resistance in treatment. In case presentation discussed in this article, Ms. A would routinely begin the sessions by describing how tired she felt, especially following a session where highly sensitive and emotionally linked material was discussed. It is important to clarify the patient's definition of "tired" and not to assume that her meaning is the same as your own. This is especially important because many older adults do not have a contemporary psychological lexicon for accurately describing their trauma symptoms and may misunderstand the process of psychological treatment.[9]

COURSE OF TREATMENT

Of the limited studies looking at dynamic psychotherapy as a treatment for PTSD in elderly persons, Hogelend was able to show that increasing insight over an extended period was the most influential factor in determining dynamic change.[10] Working through trauma by talking about raw past emotions felt then and now has to be done at a slower pace than that which may be used in a younger person. Readdressing the goals of therapy during acute regression periods is needed repeatedly in order to refocus the patient.

In this case, since Ms. A was traumatized previously by a male figure of authority, it was important to create an atmosphere that was safe for her to express her feelings. This required gaining her trust and assuring her of the psychiatrist's intentions. The patient was reassured on multiple occasions that the therapeutic relationship was secure and that she would not be abandoned. This meant the psychiatrist needed to return her phone calls promptly and during periods in which there was adequate time for consultation. It became especially evident that this was very important to the patient after the psychiatrist took a vacation and was away from the patient. During the time the psychiatrist was away, Ms. A regressed and required a brief hospitalization for observation. During the following sessions, the psychiatrist addressed her concerns and her fears. In particular, the patient feared that she would not be taken care of and felt vulnerable and exposed.

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Eventually, the patient was able to redirect her long-standing rage toward her old boss. She came to realize that it was possible to be angry with him now without terrible consequences, as this was processed through the transference. When she occasionally expressed anger toward the psychiatrist, this was accepted and she was not abandoned or punished for her feelings. As the sessions continued, the patient's anxiety decreased at home and within the sessions. She and her husband began to spend time together and began displaying nonintimate touching. The patient felt more comfortable expressing her needs to her husband. She was able to express a less fearful attitude toward her current boss, and the fear that he too would exploit her continued to decrease.

TRANSFERENCE

It is imperative for the patient to be able to depend on the therapeutic relationship. The patient enters the relationship questioning whether the therapist can or will help.[11] Through the transference, the patient is able to experience a therapeutic relationship where he or she feels in control and safe. With Ms. A, it was important to help her gain a better understanding of her feelings of vulnerability, which appeared to be influenced by her prior trauma and her current phase of life issues, e.g., finances, aging, and retirement. In elderly patients, this may be difficult since they may see a therapist or psychiatrist as being like a son or daughter, yet have the transference-based hopes they would have of a parent.

As Ms. A continued to describe her feelings of helplessness in coping with her gynecologic care, she was able to acknowledge having ambivalent feelings toward her psychiatrist. The patient admitted that she had periods in which she wanted to leave therapy because she was not sure that she could ever allow herself to be so dependent on anyone.

COUNTERTRANSFERENCE

Countertransference issues are potentially powerful elements of geriatric psychotherapy, and are likely to escape the attention of the therapist unaccustomed to treating older patients. The therapist may see a frail

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but demanding elder as helpless and may indulge in inappropriate rescue fantasies, setting him- or herself up for feelings of failure. He or she may then resent the patient for having been so helpless in the first place. Further disappointment is possible if the therapist unwittingly wishes the patient to be a more powerful or competent parent figure. The therapist must carefully process his own feelings about the geriatric patient. He may find himself wanting to protect her. There may be thoughts of whether he is capable of helping the patient through her crisis. Having aging parents himself, he may be so "sympathetic" that he becomes less objective and, paradoxically, less empathic to his patient's real concerns.

TERMINATION

The goal of psychotherapy in PTSD is to reduce or eradicate symptoms and to assist the patient in regaining normalcy in function through integration of the past with the present.[11] When a patient has reached this point, it may be appropriate for the patient or therapist to broach the subject of termination. Ultimately the decision to terminate should be a mutual decision. This phase of treatment may be difficult for both the therapist and patient. The two may be reluctant to end the relationship due to the significance of the relationship for each individual. Common experiences that may present at termination may include ambivalent feelings by the patient toward the therapist, feelings of grief and loss, recurrence of symptoms, or reactivation of the initial conflict.

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PRACTICE POINT

Psychic trauma in childhood or adulthood may not produce immediate symptoms or overt distress. Events of later life, however, may awaken long-suppressed memories and feelings and yield emotional or behavioral problems. In the case described in this article, a woman of late middle age was a victim of sexual trauma in earlier adulthood, an experience she had effectively suppressed and then repressed. As she had to subject herself to intrusive medical examination by unfamiliar physicians, she became anxious and depressed. A first effort to deal with the current situation effected only temporary relief. It was only after the examination and processing of the older trauma that resolution became possible.

CONCLUSION

Manifestations of past trauma can be obscure in the elderly. Symptoms may be delayed, as in the case presented, and they may not be the classical ones of PTSD. Instead, more diffuse manifestations of anxiety and depression may emerge. Exploration of these issues in older individuals requires a slower pace and more gentle inquiry than in younger patients. Working through and resolution usually demands multiple rounds of repetition and practicing. Transference is not much affected by age, but the therapist's countertransference may be heavily colored by his or her own experiences with parents and other aging figures.

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